

AFFIDAVIT

THE STATE OF TEXAS

COUNTY OF WALKER

§
§
§

BEFORE ME, the undersigned authority, personally appeared **Lisa Lopez**, who, being by me duly sworn, deposed as follows:

“My name is **Lisa Lopez**, and I am over the age of eighteen (18), of sound mind, competent and capable of making this affidavit, and personally acquainted with the facts herein stated:

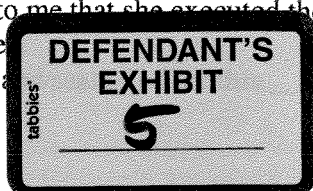
I am the Custodian of Records at The University of Texas Medical Branch - Correctional Managed Care, Health Services Archives and my office is located in Huntsville, Texas. In this capacity, I am the individual who can authenticate and certify as official, copies of medical records at the **TDCJ Health Services Archives**. Attached hereto are **21** pages of records, time period **July 15, 2011** to **July 22, 2011** from the medical records of **Larry McCollum, TDCJ # 1721640**. These said records are kept in the regular course of business by an employee or representative of UTMB-Correctional Managed with knowledge of the act, event, condition, opinion or diagnosis, recorded or to transmit information thereof to be included in such record; and the record was made at or near the time or reasonably soon thereafter. The records attached hereto are the original or exact duplicates of the original and no other documents exist in the files on the above named person at **TDCJ Health Services Archives**”.


Lisa Lopez

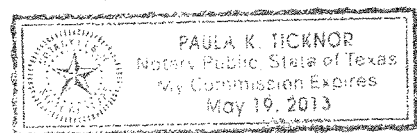
State of Texas,
County of Walker

Before Me Paula K. Ticknor on this day personally appeared Lisa Lopez, known to me through her Texas Driver's License to be the person whose name is subscribed to the foregoing instrument and acknowledge to me that she executed the same for the purpose and consideration therein expressed.

Given under my hand and seal
A.D., 2013



22nd day of Feb,



MCCOLLUM 004

Scanned by HICKS, STEPHANIE K. CCA in facility HUTCHINS (HJ) on 07/20/2011 13:32

TEXAS UNIFORM HEALTH STATUS UPDATE

I. NAME: McCollum LARRY G. DOB: 4/04/53 AGE: 58
 Last First MI
 STATE ID# 3950494 RACE: W SEX: Male ☒ Female ☐
 COUNTY/TDCJ# 34610 WT. 330 HT: 5'10

II. CURRENT/CHRONIC HEALTH PROBLEMS

A. Health Problems

- ☐ 1. None
☐ 2. Asthma
☐ 3. Pregnancy
☐ 4. Dental Priority
☐ 5. Diabetes
☐ 6. Drug Abuse
☐ 7. Alcoholism
☐ 8. Orthopedic Problems
☐ 9. Cardiovascular/Heart Trouble
☐ 10. Suicidal
☐ 11. Mental Retardation
☐ 12. Mental Illness (Specify diagnosis) _____
☐ 13. Recent Surgery
☐ 14. Seizures
☐ 15. Dialysis
☒ 16. Hypertension
☒ 17. CARE System Y/N ☒

III. SPECIAL NEEDS (Check all that apply)

A. Housing Restrictions

- ☒ 1. None
☐ 2. Skilled Nursing Facility
☐ 3. Extended Care Facility
☐ 4. Psychiatric Inpatient Facility
☐ 5. Respiratory Isolation
☐ 6. Other.

B. Transportation

- ☒ 1. Routine
☐ 2. Crutches/Cane
☐ 3. Ambulance
☐ 4. Wheelchair/Wheelchair Van
☐ 5. Prosthesis:

C. Pending Specialty Clinic Appointment

None ☒ Type _____D. ALLERGIES NKA

NKA _____

*NOTE When screening substance abuse facility clients, please contact the TDCJ-ID Health Services Liaison at (936)437-3589 for clients with any chronic disease symptoms deemed unstable.

B. Preventive Medicine

- ☒ 1. Tuberculosis Status
 Skin Test: Date Given: 6/28/11 Date Read: 6/27/11 Results + mm*
 X-Ray: Date: /// Normal Abnormal * Anti-TB Treatment? No Yes *
☐ 2. Hepatitis: A B C Other:
☐ 3. HIV Antibody: Test Date: /// Results: Neg Pos CD4: Date ///
☐ 4. Syphilis: Date: /// Type: Treatment Completed: Yes No

*NOTE: If any treatment has been recommended, the X-Ray was abnormal, or skin test indicates infection please attach tuberculosis record.

C. Other Health Care Problems: noneIV. CURRENT PRESCRIBED MEDICATIONS None

Medication	Dosage	Frequency
<u>Clonidine</u>	<u>0.1mg ÷ tab P.O</u>	<u>PRN BP</u>

THIS FORM MUST ACCOMPANY ALL OFFENDERS TRANSFERRED TO AND FROM ALL TEXAS CRIMINAL JUSTICE ENTITIES

COMPLETED BY: Shelia Smith RN DATE: 7/15/11
 Signature/Title
 PHONE NUMBER: 254-757-2555 FACILITY: MCCOLLUM County Jail

MCCOLLUM 017

Patient Name: MCCOLLUM, LARRY G Patient DOB: 04/04/1953

Patient ID: 1716091 Service Date: 07/20/2011 08:42:00

Lab Data Imported From and Tests Performed By:

LabCorp 1-800-292-4021

Patient Name : MCCOLLUM, LARRY G
 Patient Id : 1721640
 Patient Phone :
 Date of Birth : 04/04/1953
 SS#

Sex : Male

Ordering

Physician : ORIG, TITO
 Facility : HUTCHINS (HJ)
 1500 E. LANGDON RD
 HUTCHINS TX 75241

Test Name	Result	ABN Flag	Unit	Reference Range
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Accession: 32858464 Requisition: 32858464
 Drawn: 07/20/11 08:42 Received: 07/20/11 23:40 Reported: 07/21/11 08:43

Procedure: CBC With Differential/Platelet

WBC	13.1	H	x10E3/uL	4.0-10.5
RBC	4.63		x10E6/uL	4.10-5.60
Hemoglobin	14.8		g/dL	12.5-17.0
Hematocrit	43.4		%	36.0-50.0
MCV	94		fL	80-98
MCH	32.0		pg	27.0-34.0
MCHC	34.1		g/dL	32.0-36.0
RDW	15.2	H	%	11.7-15.0
Platelets	204		x10E3/uL	140-415
Neutrophils	60		%	40-74
Lymphs	32		%	14-46
Monocytes	8		%	4-13
Eos	0		%	0-7
Basos	0		%	0-3
Immature Cells				
Neutrophils (Absolute)	7.7		x10E3/uL	1.8-7.8
Lymphs (Absolute)	4.3		x10E3/uL	0.7-4.5
Monocytes (Absolute)	1.1	H	x10E3/uL	0.1-1.0
Eos (Absolute)	0.0		x10E3/uL	0.0-0.4
Baso (Absolute)	0.0		x10E3/uL	0.0-0.2
Immature Granulocytes	0		%	0-2

Please note reference interval change

Immature Grans (Abs) 0.0 x10E3/uL 0.0-0.1
 NRBC

Hematology Comments:

Procedure: Comp. Metabolic Panel (14)

Glucose, Serum	130	H	mg/dL	65-99
BUN	31	H	mg/dL	6-24
Creatinine, Serum	1.67	H	mg/dL	0.76-1.27
eGFR If NonAfricn Am	44	L	mL/min/1.73 m2	>59
eGFR If Africn Am	51	L	mL/min/1.73 m2	>59

Note: A persistent eGFR <60 mL/min/1.73 m2 (3 months or more) may indicate chronic kidney disease. An eGFR >59 mL/min/1.73 m2 with an elevated urine protein also may indicate chronic kidney disease.

Print Date: 07/21/2011 07:53

Page: 1/4

Data Imported From and Tests Performed By:

LabCorp 1-800-292-4021

Patient Name : MCCOLLUM, LARRY G
 Patient Id : 1721640
 Patient Phone :
 Date of Birth : 04/04/1953
 SS# : 000-00-3517

Sex : Male

Ordering

MCCOLLUM 007

HUTCHINS (HJ) 1500 E. LANGDON RD HUTCHINS TX 75241 Tel. 9722251304 Page 1 of 4

Patient Name: MCCOLLUM, LARRY G Patient DOB: 04/04/1953

Patient ID: 1716091 Service Date: 07/20/2011 08:42:00

Physician : ORIG, TITO
 Facility : HUTCHINS (HJ)
 1500 E. LANGDON RD
 HUTCHINS TX 75241

Test Name	Result	ABN Flag	Unit	Reference Range
Calculated using CKD-EPI formula.				
BUN/Creatinine Ratio	19			9-20
Sodium, Serum	133	L	mmol/L	135-145
Potassium, Serum	3.5		mmol/L	3.5-5.2
Chloride, Serum	91	L	mmol/L	97-108
Carbon Dioxide, Total	18	L	mmol/L	20-32
Verified by repeat analysis				
Calcium, Serum	8.8		mg/dL	8.7-10.2
Protein, Total, Serum	7.8		g/dL	6.0-8.5
Albumin, Serum	4.0		g/dL	3.5-5.5
Globulin, Total	3.8		g/dL	1.5-4.5
A/G Ratio	1.1			1.1-2.5
Bilirubin, Total	0.8		mg/dL	0.0-1.2
Alkaline Phosphatase, S	56		IU/L	25-150
AST (SGOT)	34		IU/L	0-40
ALT (SGPT)	21		IU/L	0-55

Procedure: Urinalysis, Complete

Specific Gravity	1.028			1.005-1.030
pH	5.5			5.0-7.5
Urine-Color	Yellow			Yellow
Appearance	Cloudy	A		Clear
WBC Esterase	1+	A		Negative
Protein	1+	A		Negative/Trace
Glucose	Negative			Negative
Glucose Reflex				
Ketones	Trace	A		Negative
Occult Blood	Negative			Negative
Bilirubin	Negative			Negative
Urobilinogen, Semi-Qn	0.2		mg/dL	0.0-1.9
Nitrite, Urine	Negative			Negative
Microscopic Examination	See below:			

Procedure: Microscopic Examination

WBC	>30	A	/hpf	0 - 5
RBC	0-3		/hpf	0 - 3
Epithelial Cells (non renal)	0-10		/hpf	0 - 10
Epithelial Cells (renal)				
Casts	Present	A	/lpf	None seen
Cast Type	Hyaline casts			N/A

Print Date: 07/21/2011 07:53

Page: 2/4

Data Imported From and Tests Performed By:

LabCorp 1-800-292-4021

Patient Name : MCCOLLUM, LARRY G
 Patient Id : 1721640
 Patient Phone :
 Date of Birth : 04/04/1953
 SS# : 000-00-3517 Sex : Male

Ordering

Physician : ORIG, TITO
 Facility : HUTCHINS (HJ)
 1500 E. LANGDON RD
 HUTCHINS TX 75241

Test Name	Result	ABN Flag	Unit	Reference Range
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MCCOLLUM 008

Patient Name: MCCOLLUM, LARRY G Patient DOB: 04/04/1953

Patient ID: 1716091 Service Date: 07/20/2011 08:42:00

Crystals

Crystal Type

Mucus Threads	Present	Not Estab.
Bacteria	Few	None seen/Few
Yeast		
Trichomonas		
Comment		

Procedure: Urinalysis, Complete
Microscopic Examination

Procedure: Lipid Panel

Cholesterol, Total	157		mg/dL	100-199
Triglycerides	195	H	mg/dL	0-149
HDL Cholesterol	16	L	mg/dL	>39

According to ATP-III Guidelines, HDL-C >59 mg/dL is considered a negative risk factor for CHD.

VLDL Cholesterol Cal	39		mg/dL	5-40
LDL Cholesterol Calc	102	H	mg/dL	0-99

Procedure: Panel 083824

HIV 1/0/2 Abs-Index Value	<1.00	<1.00
Index Value: Specimen reactivity relative to the negative cutoff.		
HIV 1/0/2 Abs, Qual	Non Reactive	Non Reactive

Procedure: Hgb A1c with eAG Estimation

Hemoglobin A1c	6.2	H	%	4.8-5.6
Increased risk for diabetes:				5.7 - 6.4
Diabetes:				>6.4
Glycemic control for adults with diabetes:				<7.0
Estim. Avg Glu (eAG)	131		mg/dL	

Procedure: TSH

TSH	2.860		uIU/mL	0.450-4.500
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Procedure: RPR

RPR	Non Reactive	Non Reactive
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L Low, H High, C Critical, * Abnormal Alpha

Print Date: 07/21/2011 07:53

Page: 3/4

Data Imported From and Tests Performed By:

LabCorp 1-800-292-4021

Patient Name : MCCOLLUM, LARRY G

Patient Id : 1721640

Patient Phone :

Date of Birth : 04/04/1953

SS# : 000-00-3517 Sex : Male

Ordering

Physician : ORIG, TITO

Facility : HUTCHINS (HJ)

1500 E. LANGDON RD

HUTCHINS TX 75241

Test Name	Result	ABN Flag	Unit	Reference Range
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MCCOLLUM 009

Patient Name: MCCOLLUM,LARRY G Patient DOB: 04/04/1953

Patient ID: 1716091 Service Date: 07/20/2011 08:42:00

Print Date: 07/21/2011 07:53

Page: 4/4

Electronically Signed by ORIG, TITO M. M.D. on 08/03/2011.

##And No Others##

MCCOLLUM 010

Scanned by GUZMAN, SANDRA in facility HUTCHINS (HJ) on 07/28/2011 08:48

aged Care
CID CLINIC NOTE
HIV PRE-TEST COUNSELING

Patient Name McCollum, LarryTDCJ # 1721640Date 07/15/2011Facility HUTCHINS (HJ)

Vitals BP _____ Wt _____ Height _____ Pulse _____ Resp _____ Temp _____

Patient Language:		Name of Interpreter, if required: NA	
S:	Chief Complaint:	<input checked="" type="checkbox"/>	Patient offered HIV testing per policy 14 11
		<input checked="" type="checkbox"/>	Pre-release HIV test
		<input type="checkbox"/>	Patient requesting HIV test
		<input type="checkbox"/>	Patient reported history of previous positive HIV test
		<input type="checkbox"/>	Other (specify)
O:	Yes	No	Mark "Yes" or "No" for the following:
		<input checked="" type="checkbox"/>	Patient is symptomatic (list symptoms)
		<input checked="" type="checkbox"/>	The patient requests HIV testing and gave a history of the following risk factors
		<input checked="" type="checkbox"/>	Injected nonprescription drugs
		<input checked="" type="checkbox"/>	Unprotected sexual activity with multiple sex partners (male and/or female)
		<input checked="" type="checkbox"/>	Tattoo
		<input checked="" type="checkbox"/>	Patient received blood transfusions or blood products
		<input checked="" type="checkbox"/>	The patient's TB skin test was positive
		<input checked="" type="checkbox"/>	Exposed staff to blood or other potentially infectious body fluids
		<input checked="" type="checkbox"/>	Patient was potentially exposed to blood and/or body fluids
	<input checked="" type="checkbox"/>		Patient offered HIV testing per policy 14 11
	A:	<input checked="" type="checkbox"/>	
<input checked="" type="checkbox"/>			High risk
P:	Yes	No	Mark "Yes" or "No" for the following:
	<input checked="" type="checkbox"/>		HIV pre-test counseling and HIV antibody testing is offered
	<input checked="" type="checkbox"/>		Discuss HIV prevention recommendations 1 Behave as if positive 2 Abstinence from sex, drugs and tattooing 3 Mutually monogamous relationships
	<input checked="" type="checkbox"/>		Review partner notification procedures should the patient test positive
	<input checked="" type="checkbox"/>		The patient gave their verbal consent for HIV antibody testing (If consent given, obtain provider order for HIV testing)
		<input checked="" type="checkbox"/>	The patient refused HIV antibody testing Obtain their signature on a Refusal of Treatment form (HSM-82)
	<input checked="" type="checkbox"/>		Health teaching offered stressing the importance of plan of care compliance
	<input checked="" type="checkbox"/>		If potential exposure, report incident to Preventive Medicine department
	<input checked="" type="checkbox"/>		Patient verbalized level of understanding of the testing procedure, confidentiality and that they would not be rescheduled to receive negative test results, but only for positive or equivocal indeterminate results

Nurse Signature. VMC RingerDate / Time 07/15/2011 @ 0900

05/01/2009

MCCOLLUM 018

Scanned by GUZMAN, SANDRA in facility HUTCHINS (HJ) on 07/28/2011 08:48:48

aged Care
CID ABSTRACT OF IMMUNIZATIONS
Tuberculin Skin Tests

Patient Name McCollum, Larry TDCJ # 1721641Date 07/15/2011 Facility HUTCHINS (HJ)

Vitals BP _____ Wt _____ Height _____ Pulse _____ Resp _____ Temp _____

Patient Language: _____ Name of Interpreter, if required: NA

MANTOUX PPD				
DATE/TIME GIVEN	MFG/LOT #	LFA	RFA	ROUTE
07/15/2011	JHP PHARM 148613			Intradermally

IMMUNIZATIONS							
DATE/TIME GIVEN	MFG/LOT #	DOSE	ROUTE	TYPE OF VACCINE	SITE	REACTION	SIGNATURE/TITLE
07/15/2011	SANOFLI-PAST U3399AA	0.5 mL	IM	Td Booster	<input checked="" type="checkbox"/> L Deltoid <input type="checkbox"/> R Deltoid	NARN	<i>VMcR... LVN</i>
		0.5 mL	<input type="checkbox"/> Sub Q <input type="checkbox"/> IM	Pneumococcal Vaccine	<input type="checkbox"/> L Deltoid <input type="checkbox"/> R Deltoid <input type="checkbox"/> Outer aspect of L or R upper arm		
		0.5 mL	IM	Influenza	<input type="checkbox"/> L Deltoid <input type="checkbox"/> R Deltoid		
		1.0 mL	IM	Hepatitis A #1 Vaccine	<input type="checkbox"/> L Deltoid <input type="checkbox"/> R Deltoid		
		1.0 mL	IM	Hepatitis A #2 Vaccine	<input type="checkbox"/> L Deltoid <input type="checkbox"/> R Deltoid		
		0.5 mL	Sub Q	Meningococcal	<input type="checkbox"/> Outer aspect of L or R upper arm		
		0.5 mL	Sub Q	Varicella #1	<input type="checkbox"/> Outer aspect of L or R upper arm		
		0.5 mL	Sub Q	Varicella #2	<input type="checkbox"/> Outer aspect of L or R upper arm		
		1.0 mL	IM	Hepatitis B #1 Vaccine	<input type="checkbox"/> L Deltoid <input type="checkbox"/> R Deltoid		
		1.0 mL	IM	Hepatitis B #2 Vaccine	<input type="checkbox"/> L Deltoid <input type="checkbox"/> R Deltoid		
		1.0 mL	IM	Hepatitis B #3 Vaccine	<input type="checkbox"/> L Deltoid <input type="checkbox"/> R Deltoid		
		0.5 mL	Sub Q	Measles/Mumps Rubella (MMR)	<input type="checkbox"/> Outer aspect of L or R upper arm		

Nurse Signature *VMcR... LVN*Date / Time 07/15/2011 @0900HSM-2
05/01/2009

MCCOLLUM 019

Scanned by GUZMAN, SANDRA in facility HUTCHINS (HJ) on 07/28/2011 08:48

58

**Correctional Managed Care
CID INTAKE INTERVIEW**Patient Name: McCullum, LarryTDCJ #: 1721640

Date: 07/15/2011 _____

Facility: HUTCHINS (HJ) _____

Vitals BP: _____ Wt: _____ Height: _____ Pulse: _____ Resp: _____ Temp: _____

Patient Language: _____

Name of interpreter, if required: NA

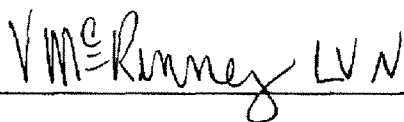
S:	CHIEF COMPLAINT:				CID intake processing including pre-test HIV counseling
O:	YES	NO	REFUSED	N/A	Mark "Yes", "No" or "Refused" for the following:
	X				HIV - Patient verbally agrees to HIV testing per state law (if yes mark Plan line 1a, if no or refused obtain HSM-82 and mark Plan line 10)
	X				RPR - RPR test is required by state and policy/procedure #14 12 (if yes mark Plan line 1b, if no or refused obtain HSM-82)
		X			MMR - Born after 1956 - 1953
	X				MMR - Attended Texas Schools (if no mark Plan line 2, or obtain refusal HSM-82)(If pregnant, mark N/A)
		X			HBV - Allergic to yeast
		X			HBV - Hepatitis B vaccine available - If no skip next two lines
					HBV - Agrees to Hepatitis B vaccine (if yes mark Plan line 3, if no obtain "Refusal of HBV Vaccine" HSM-98)
					HBV - Consent for hepatitis B vaccine signed (form 100E) or refusal signed
		X			TB - History of positive TB skin test - written documentation (if no and less than 45 years of age mark Plan line 4, if yes or refused mark Plan line 5)
					TB - If yes - date _____ CPX _____ months (if CPX taken less than 6 months or currently taking CPX mark Plan line 6)
					TB - Patient 45 years of age or older and no documentation available to verify a previous positive Mantoux skin test (if yes, mark Plan line 11)
	X				Tetanus & Diphtheria - Verbally agrees to Tetanus and Diphtheria Toxoid Booster (mark Plan line 7 if yes, if no or refused obtain HSM-82)
	YES	NO	UNKNOWN		
	X				History of varicella (if yes mark Plan line 9 to add alert code 5290 to MPL/Problem list, if no mark MPL/Problem list for possibly susceptible)
					If female, is patient pregnant? If yes how many weeks: _____ (if yes or unknown mark Plan line 8)
A:					Alteration Health Maintenance

Scanned by GUZMAN, SANDRA in facility HUTCHINS (HJ) on 07/28/2011 08:48

Correctional Managed Care CID INTAKE INTERVIEW

P:	PLAN:
X	1a Obtain order for lab to draw HIV
X	1b Obtain order for lab to draw RPR
	2 Obtain order for MMR 0 5cc vaccine sub q
	3 Obtain order for Hepatitis B vaccine 20mcg/1ml – administer hep B vaccine at 0, 1 and 6 months if indicated per TDCJ policy
X	4 Obtain order for PPD 0 1cc ID (L) forearm and will check within 48-72 hours
	5 Obtain order for CXR single view
	6 Refer to provider to schedule for ITP/TB Chronic Clinic
X	7 Obtain order for Tetanus and Diphtheria Toxoid Booster 0 5cc vaccine IM
X	8 Refer to provider to schedule appointment
X	9 Add alert code 5290 to MPL/Problem List
X	10 Add alert code 1112 to MPL/Problem List (indicates HIV high risk screening completed)
X	11 Obtain order for two-step Mantoux skin test (PPD 0 1cc ID (L) forearm and will check within 48-72 hours. If the reaction is lesser than 10 mm of induration, the second step is administered one to two weeks later)
	REFER TO PROVIDER:
X	1a Order for lab to draw HIV
X	1b Order for lab to draw RPR
	2 Order for MMR 0 5cc vaccine sub q
	3 Order for Hepatitis B vaccine 20mcg/1ml – administer hep B vaccine at 0, 1 and 6 months if indicated per TDCJ policy
X	4 Order for PPD 0 1cc ID (L) forearm and will check within 48-72 hours
	5 Order for CXR single view
	6 Schedule appointment for ITP/TB Chronic Clinic
X	7 Order for Tetanus & Diphtheria Toxoid 0 5cc vaccine IM
X	8 Schedule appointment with provider
	9 Administer flu vaccine 0 5 CC IM x 1 if indicated per TDCJ policy
X	10 Order for two-step Mantoux skin test (PPD 0 1cc ID (L) forearm and will check within 48-72 hours. If the reaction is lesser than 10 mm of induration, the second step is administered one to two weeks later)

Nurse Signature: _____


Date / Time: 07/15/2011 @ 0900

MCCOLLUM 022

Scanned by HICKS, STEPHANIE K. CCA in facility HUTCHINS (HJ) on 07/20/2011 13:31

CORRECTIONAL MANAGED CARE
INTAKE HISTORY AND HEALTH SCREENING

1721640

I. IDENTIFICATION

NAME: McCollum, Larry OCCUPATION: Driver EDUCATION: High School
 DOB: 04/04/53 COUNTY: McCollum PREVIOUS TDCJ #(s): _____

II. FAMILY HISTORY

1 Blood disease (sickle cell anemia, hemophilia)	YES	NO	18 INH Prophylaxis	YES	NO
2 Cancer	YES	NO	19 Intravenous Drug Abuse	YES	NO
3 Diabetes	YES	NO	20 Kidney Disease	YES	NO
4 Heart Disease	YES	NO	21 Liver Disease	YES	NO
5 High Blood Pressure	YES	NO	22 Mental Illness	YES	NO
6 Tuberculosis	YES	NO	23 Non Intravenous Drug Abuse/Alcoholism	YES	NO
III. PERSONAL HISTORY			24 Peptic Ulcers		
11 D 1 Asthma/Emphysema	YES	NO	25 Rheumatic Fever	YES	NO
12 Back Injury	YES	NO	26 Rheumatism/Arthritis	YES	NO
13 Blood Disease (sickle cell anemia, hemophilia)	YES	NO	27 Seasonal Allergies	YES	NO
14 Cancer	YES	NO	28 Sexually Transmitted Diseases	YES	NO
15 Cavities	YES	NO	29 Smoker	YES	NO
16 Depression/Suicide Attempt	YES	NO	30 Tetanus Immunization Date	YES	NO
17 Diabetes	YES	NO	31 Tuberculosis	YES	NO
18 Drug/Food Allergies	YES	NO	32 Unprotected Sex w/Multiple Partners	YES	NO
19 Epilepsy/Seizures	YES	NO	33 Other		
10 Glasses/Hearing Aid	YES	NO	IV. OBSTETRIC/GYNECOLOGIC AL HX		
11 Gum disease	YES	NO	1 Date of last menstrual period		
12 Head Injury	YES	NO	2 Number of pregnancies/live births		
13 Heart Disease/Angina	YES	NO	3 History of Problem pregnancy		
14 Hepatitis	YES	NO	4 Date of last pap smear		
15 High Blood Pressure	YES	NO	5 Date of last mammogram		
16 HIV + / AIDS	YES	NO	6 History of birth control methods (IUD, pills, etc.)		
Prior HIV Test Date		NO			
17 Homosexual/Bisexual Activities		NO			
A. If YES to any of the above indicate family member or self, give date and treatment received					
<u>② Father, Brother</u>					
B. History of hospitalization? YES NO <u>Hillman Hospital</u>					
Please list the DATE, HOSPITAL, CONDITION					
C. Do you have any current medical, mental health or dental complaints? YES NO					
If yes, what <u>tooth pull, Depression</u>					
D. Have you experienced any of these symptoms cough, weakness, weight loss, fevers, night sweats, loss of appetite or lethargy?					
YES (NO) If YES, when?					
E. What illegal drugs have you used? <u>NO</u>					
What was the mode(s) of use? (Please circle) Smoking Injection Inhaled Ingested					
What amount and how often did you use drugs and alcohol?					
When was the last time you used drugs or alcohol?					
Have you ever had withdrawal or seizures when you stopped using drugs or alcohol? YES NO					
F. Are you presently taking or supposed to be taking any prescribed medications? YES NO					
If YES, what <u>See Med Sheet</u>					

HSM-13 (6/06)

MCCOLLUM 023

Scanned by HICKS, STEPHANIE K. CCA in facility HUTCHINS (HJ) on 07/20/2011 13:32

CORRECTIONAL MANAGED CARE
INTAKE HISTORY AND HEALTH SCREENING

Reason for taking medications									
G	Observations	Tremor	YES	NO	Sweating	YES	NO	Other	
	Condition of skin	Cuts	YES	NO	Bruises	YES	NO		
		Sores	YES	NO	Other				
	Body & Movement	Deformities	YES	NO	Impaired Motor Activity	YES	NO		
		Other							
H BEHAVIOR AND MENTAL STATUS									
	Hygiene & Appearance	<input checked="" type="checkbox"/> Clean, neat		Dirty, sloppy		Other			
	Orientation (ask questions and document response)								
	What is today's date?	7/15/11							
	What time is it?	Morning							
	What place is this?	Juchin							
	Speech	<input checked="" type="checkbox"/> Normal		Loud		Soft		Mumbling	
	Attitude	<input checked="" type="checkbox"/> Appropriate		Laughing		Crying		Cursing	
						Quiet		Other	
I THOUGHT CONTENT (Please circle YES or NO)									
	Are you having current thoughts about suicide or self-injury?					YES	NO		
	Do you see or hear things that others do not see or hear?					YES	NO		
	Do you have any special powers abilities?					YES	NO		
	Do you receive personal messages from the TV or radio?					YES	NO		
	Do you have any phobias or excessive fears?					YES	NO		
J. DISPOSITION									
	Routine referral to	<input checked="" type="checkbox"/> Medical		<input checked="" type="checkbox"/> Mental Health		<input checked="" type="checkbox"/> Dental		<input checked="" type="checkbox"/> CID	
	Immediate referral to	<input checked="" type="checkbox"/> Medical		<input checked="" type="checkbox"/> Mental Health		<input checked="" type="checkbox"/> Dental		<input checked="" type="checkbox"/> CID	
	Release to general population	<input checked="" type="checkbox"/> YES		NO		Other			

Offender Signature:	<i>Larry McCall</i>	Date:	7-15-11
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Reviewer Signature:	<i>Dr. H. H. H. H.</i>	Date:	7/15/11
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Accepted on 7/18/11

HSM-13 (5/06)

MCCOLLUM 024